MENT OF HEALTH AND HUMAN SERVICES
CARE FINANCING ADMINISTRATION

DYSON

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 7 — 0 1 6

2. STATE: Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 1997

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 413.86

7. FEDERAL BUDGET IMPACT: Approx. 3%
a. FFY _____ $ _____
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Section 4.19-A, pp. 1, 2, 4, 6b, 10, 11, 11a, 12, 17a, 19, 20, 21 and 31-35. Section 4.19-B, pp. 2, 2a and 2c.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Section 4.19-A pp. 1, 2, 4, 6b, 10, 11, 11a, 12, 17a, 19, 20, 21 and 31-35. Section 4.19-B, pp. 2, 2a and 2c.

10. SUBJECT OF AMENDMENT:
Graduate Medical Education (GME)

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
James K. Haveman, Jr.

14. TITLE:
Director

15. DATE SUBMITTED:
9/25/97

16. RETURN TO:
Michigan Department of Community Health
Medical Services Administration
P.O. Box 30479
Lansing, MI 48909-7979

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9-26-97

18. DATE APPROVED:
6/6/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7-1-97

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS OF PAYMENT OF REASONABLE COSTS -
INPATIENT HOSPITAL SERVICES

I. Principle

A. Reimbursement Type

The Michigan Medicaid Program impatient reimbursement system is applicable for inpatient hospital services rendered to recipients under the Medicaid and Crippled Children's programs and to recipients with dual Medicare/Medicaid eligibility.

Reimbursement for inpatient services rendered to recipients with dual Medicare/Medicaid eligibility will be the Medicaid amount less Medicare reimbursement, but not less than zero. Medicaid reimbursement will be limited to a maximum of the Medicare coinsurance and deductible amounts. For patients who have exhausted their Medicare Part A coverage, Medicaid will provide reimbursement for capital. Medicaid will not pay capital for any other recipients with dual Medicare/Medicaid eligibility.

1. Diagnosis Related Groups

All hospitals participating in the Medical Assistance Program are reimbursed for operating costs based on Diagnosis Related Groups (DRGs). Exceptions are listed below.

2. Prospective Per Diem

The following groups of hospitals or units are reimbursed for operating costs on a prospective per diem basis:

- freestanding rehabilitation hospitals which are excluded from the Medicare prospective payment system (PPS),
- freestanding psychiatric hospitals which are excluded from the Medicare PPS, and
- distinct-part psychiatric units of general hospitals which have been certified by Medicare and excluded from its PPS.

Services provided to patients in subacute ventilator-dependent units are reimbursed using a prospective per diem rate that includes capital and direct medical education costs.

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3. TEFRA Limited Cost Based

State-owned psychiatric hospital are reimbursed for allowable operating costs under Medicare Principles of Reimbursement with TEFRA limits applied.

4. Cost Reimbursement

The operating payment for services provided to Medicaid recipients in distinct part rehabilitation units will be made at full cost using Medicare principles of allowable costs.

5. Capital

Capital costs are reimbursed using a system based on allowable costs with occupancy limitations for some hospitals and units.

6. Graduate Medical Education

Graduate medical education costs are reimbursed by formula and grant as explained in Section III-J.

B. Lesser of Rate or Charges

Total payments for program inpatient services will be limited to the lesser of total payments or full charges, in aggregate, for each hospital. If the aggregate program charges are less than total payments, the difference will be gross adjusted. This review and adjustment will occur coincident with adjustments for capital, at the facility fiscal year end.

C. Interim payments will be made in compliance with 42 CFR 413.60 et seq.

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B. Audit

Audits are performed for Michigan inpatient hospital services provided after February 1, 1985 to determine program cost for capital using Medicare Principles of Reimbursement.

Once any appropriate limits are applied, the capital cost is added to the amount approved as payment for the program operating cost to obtain a total amount approved. The total amount approved in a hospital's fiscal year is compared to the hospital's program charges. The lesser of amount approved or charges is then compared to the amount actually paid throughout the year to determine the amount overpaid or underpaid to the hospital.

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Data for current wage adjustors are taken from hospital cost reporting periods ending between October 1, 1994 and September 30, 1995. Factors from the following table will be used to neutralize for inflationary differences. The adjustors represent the employee cost component of the Data Resources, Inc. PPS-Type Hospital Market Basket index (first Quarter of 1996).

FYE	Wage Data
12/31/94	1.019
3/31/95	1.012
6/30/95	1.006
9/30/95	1.000

For hospitals with cost reporting periods ending other than at the end of a quarter, wage adustors will be updated beginning with the quarter in which the hospital's fiscal year ends.

[Deletion]

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Common inflation factors are used to bring rates through the State fiscal year beginning October 1, 1994 and were obtained from the first quarter 1994 Data Resources, Inc. PPS-Type Hospital Market Basket Index:

to 1992-93	1.029
to 1993-94	1.028
to 1994-95	1.036

Based on the adjusted DRG paid claims file, statewide operating cost limits are set at the truncated mean.

The truncated mean of DRG base prices; which have been adjusted for area cost, is determined by calculating an unweighted mean price for all DRG reimbursed Michigan hospitals that were enrolled in the Michigan Medicaid Program as of January 1, 1994, and that had base year data from 1991-92.

For hospitals whose standardized price is greater than the mean price plus 1 standard deviation the standardized prices, the standardized price is limited to the mean plus one standard deviation. A mean weighted by base periods discharges is computed with this limitation and becomes the truncated mean.

The standardized price is:

$$\frac{\textit{Hospital Specific Per Diem Rate}}{\textit{Area Cost Adjustor}}$$

[Formula deleted]

Where the area cost adjustor is

$$(0.90 \times \textit{Area Wage Adjustor}) + 0.10$$

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The number of beds for each hospital is the average number of available licensed beds for the hospital. Available licensed beds are limited to beds in the medical/surgical portion of the hospital and interns and residents are only allocated to the medical/surgical portion of the hospital. The standardized price was set using beds, interns and residents figures from hospital indigent volume survey data filed for hospital fiscal years ending between October 1, 1991 and September 30, 1992.

Each hospital's operating limit is determined by adjusting the statewide limit using wage data from filed cost reports for hospital fiscal years ending between October 1, 1992 and September 30, 1993. The base DRG price for each hospital will be limited to a maximum of this operating limit.

Each hospital's wage factor for computing the hospital's operating limit is it's county (or city of Detroit) average reported wage per hour divided by the statewide average hospital reported wage per hour. County (or city of Detroit) and statewide reported average wage per hour is calculated using DRG hospitals, including freestanding DRG children's hospitals submitted wage data only.

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To neutralize each hospital's reported wage costs for different fiscal year end dates the following adjustment factors, derived from the first quarter 1994 Data Resources, Ind. PPS-Type Hospital Market Basket Index employee cost component, will be used:

FYE	Wage & Benefit Inflation to 1994
12/31/92	1.025
03/31/93	1.016
06/30/93	1.008
09/30/93	1.000

[Deletion]

For hospitals with base DRG prices below the operating limit, the hospital's base DRG price will be increased by adding 10% of the difference between the hospital sspecific base price and the limit.

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The DRG base price for each hospital is determined using the following table:

1. Statewide DRG Operating Cost Limit
2. Hospital's Area Cost Adjustor (1990/91)
3. Hospital's DRG Operating Limit (Line 1 x Line 2)
4. Hospital's Specific Base Price
5. Hospital's DRG Price after Limit (Lesser of Line 3 or Line 4)
6. Incentive (If Line 4 is less than Line 3 then 10% of Line 3 - Line 4)
7. Hospital's DRG Base Price (Line 5 + Line 6)

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that had base year data from 1990-91 are sorted in ascending order of their standardized rate. The standardized rate for the first unit after 50% of the units have been listed becomes the statewide 50th percentile.

The standardized rate is:

$$\frac{\textit{Hospital Specific Per Diem Rate}}{\textit{Area Cost Adjustor}}$$

The are wage adjustors and the formula for the area cost adjustor are the same as those used for the DRG base price.

Once the 50th percentile has been determined, the statewide limit is set at 110% of the 50th percentile and adjustors are applied for area wage cost differences. The per diem base rate is then the lesser of the unit specific base rate or the adjusted limit.

The area wage adjustors and the formula for the area cost adjustor are the same as those used for the DRG price.

The per diem base rate is then the lesser of the unit specific base rate or the adjusted limit.

$$\textit{110\% x 50th Percentile x Area Cost Adjustor}$$

4. Distinct Part Rehabilitation Units

Effective for services on and after October 1, 1991, the operating payment for services provided to Medicaid recipients in distinct part rehabilitation units will be made at full cost using Medicare principles of allowable costs.

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F. New Hospitals and Units

A new hospital or unit is one for which no Michigan Medicaid Program cost or paid claims data exists during the period used to establish hospital specific base rates. Hospitals that experience a change of ownership or that are created as the result of a merger are not considered new hospitals.

1. General Hospitals

The DRG base price for new general hospitals will be the truncated mean DRG base price until new DRG base prices are calculated for all hospitals using data from time periods during which the new hospital provided services to Medicaid patients. The base price will be adjusted for area cost differences using the factors described above.

[Deletion]

2. New Freestanding Rehabilitation Hospitals

New freestanding rehabilitation hospitals are reimbursed using the statewide average (weighted by days during the base period) per diem rate for their type of provider. The base rate will be adjusted for area cost differences using the factors described above.

A hospital specific rate will be established when new rates are calculated using data from time periods during which the new hospital provided services to Medicaid patients.

3. New Freestanding Psychiatric Hospitals

New freestanding psychiatric hospitals are reimbursed using the statewide average (weighted by days during the base period) per diem rate for their type of provider. The base rate will be adjusted for area cost differences using the factors described above.

A hospital specific rate will be established when new rates are calculated using data from time periods during which the new hospital provided services to Medicaid patients.

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4. New Medicare Certified Distinct Part Psychiatric Units

The per diem base rate for new Medicare certified distinct part psychiatric units of general hospitals is the average (weighted by days during the base period) per diem rate for distinct part psychiatric units located in Michigan. The rate is limited to a maximum of 110% of the 50th percentile of base per diem. The base rate will be adjusted for area cost differences using the factors described above.

This rate methodology will be used for the new unit until new per diem base rates are calculated for all units using data from time periods during which the new hospital provided services to Michigan patients. Upon written request by the provider, however, a new per diem rate, based on cost, may be calculated if the hospital submits a cost report including one full year of cost information for the distinct part psychiatric unit. The new rate will become effective on the first day of the next quarter, twenty days after the latter of the request date or the date of acceptance of the cost report by MSA. This rate will based on the cost report containing one full year of cost information for the new distinct part psychiatric unit. All other information will be the same as was used in the last per diem rebasing and the cost will be subject to the same limitations and adjustments as are appropriate for other distinct part psychiatric units during the same rate period. For the state fiscal year ending September 30, 1994, the new units who qualify, may request this change effective January 1, 1994, if written request is received by June 30, 1994.

If a hospital at least doubles the number of licensed beds in its distinct part psychiatric unit and the number of licensed beds increases by at least 20, the entire unit will be treated as a new distinct part psychiatric unit for determining the per diem rate. In order for this provision to apply, the hospital must request in writing that the unit be treated as a new unit. The new unit rate will become effective on the date that the number of beds doubles and the increase is at least 20 beds, or the date on which the request is received by the MSA, whichever is later.

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G. Other Reimbursement Methods

1. Sub-acute Substance Abuse (Deleted)

2. Sub-Acute Ventilator-dependent Care

Reimbursement for services provided to patients in sub-acute ventilator-dependent care units is through a prospective per diem rate. The per diem rate covers the costs of capital, routine accommodations, regular ancillary services, and regular professional services.

The per diem rate is established using a variety of data including: cost report data (the sub-acute ventilator-dependent care unit must be treated as a separate distinct part), the rate of utilization in the unit, inflation, professional costs, the rates paid to ventilator-dependent units in long term care facilities, and the cost and availability of suitable alternative placements. Effective October 1, 1991, the per diem rate is set to not exceed the per diem rate that would be paid for outlier days under DRG 483 (Tracheostomy Except for Mouth or Pharynx Disorder).

If a need for the services exists, the rate is specified in a contract offer from the Medicaid Program to the hospital.

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J. Graduate Medical Education

The total annual Medicaid medical education payment for academic year (AY) 1997-98 (from July 1, 1997 to June 30, 1998) and AY 1998-99 will be set not to exceed the total payment made for graduate medical education in calendar year (CY) 1995.

Formula Payments to Hospitals for Health Professions Education
Payments will be made directly to hospitals by formula from two pools of funds. Payments will be fixed, prospective payments, made in full, not subject to future cost settlement, or appeal. Payments will be made only to hospitals which provide requested information by the dates required.

Historical Cost Pool
Payments to hospitals from the historical cost formula pool will be based on:

1) an estimated settlement of direct medical education for hospital cost years ending in CY 1995, and
2) a calculation of the estimated indirect medical education based on inpatient discharges that occurred, and outpatient services provided, during CY 1995.

For AY 1997-98, payments from this pool will total $166.3 million. Semi-monthly payments (24 payments during the academic year) will be made to hospitals which have submitted required reports by April 1, 1997. Settlements for direct medical education for hospital cost years ending in state FY 1997, other than June 30, 1997, will involve split year settlements.

Primary Care Pool
A primary care formula pool will be established. Payments will be distributed to eligible hospitals based on the following formula:

1) The number of full-time-equivalent (FTE) primary care interns and residents drawing salaries at each hospital will be multiplied by one plus each hospital's Medicaid volume factor (taken from the hospital's indigent volume report).
2) The product for each hospital from the above step will be divided by the sum of the individual products for all hospitals from step 1.
3) The result for each hospital from step 2 will then be multiplied by the primary care pool to determine each hospital's share of the pool.

For AY 1997-98, the primary care pool is to be $20 million. The first payment from this pool will be made in July, 1997. The last payment from the pool will be made no later than June, 1998. Payments will be made semi-monthly (24 payments during the academic year).

For purposes of distributing the primary care pool, primary care positions are defined as those interns and residents pursuing graduate medical education in general practice, family practice, general internal medicine, general pediatrics, internal medicine/pediatrics, preventive medicine, obstetrics, and geriatrics. Countable positions will be those interns and residents in the first three

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years of a primary care program that will lead to a placement in a primary care practice. In addition, the fourth year of GME may be included for internal medicine/pediatrics and obstetrics. Two years of training in geriatrics beyond the initial primary care program in internal medicine or family practice may be included. The initial year of an osteopathic or transitional rotation may be included also.

Required Reports from Hospitals Receiving Funds from the Formula Pools
To be eligible to receive a payment from the historical cost/primary care formula pools, a hospital is required to submit a report to the MSA each year. The reports shall include the following:

- A description of how the Medicaid funds from the pools are being used in the support of the "Guiding Principles of Medicaid Payment Policy for Health Professions Education"
- A list of all interns and residents by name, indicating the primary care or specialty care field in which each is training, the year of training for each, and the percentage of full time equivalent (FTE) salary allocated to that hospital, for the academic year July 1, 1996 through June 30, 1997
- Forms will be provided to the hospitals prior to February 1, 1997

Payments from the Historical and Primary Care Pools for AY 1997-98 will not be made to hospitals that do not submit the required information by April 1, 1997. To be eligible for payments in AY 1997-98 from the Historical and Primary Care Pools, hospitals must operate a GME program in AY 1997-98. Reports will be subject to field audit.

Incentive Payments for Innovations in Health Professions Education
To encourage the training of health professionals in managed care settings, a special pool will be established which may be distributed to a consortium of hospitals, universities, and/or managed care organizations that collaborate to provide or develop health profession training in managed care settings. On a competitive basis, incentive payments may be awarded to qualified applicants that respond to a request for proposal (RFP) issued by the Department.

Incentive payments will be awarded based on public policy goals and priorities. Eligible applicants for funding from this pool will include, at a minimum, a consortium including a hospital, university, and managed care organization, (and may also include a clinic, outpatient hospital clinic, federally qualified health center, rural health clinic, local public health provider or other providers) who can provide appropriately accredited training. Exceptions to this requirement may be made in the case of training programs in which participation by a hospital is not required for accreditation (e.g. a graduate nurse training program). Incentive payments will be awarded only for professional education programs that are accredited by national and/or regional accrediting agencies. An enrolled Medicaid provider must be included in, and the treatment of Medicaid patients must be part of, any consortium awarded a grant. Payments will be made to the enrolled Medicaid provider which will act as the fiduciary for the consortium.

Incentive payments may be awarded may be for multi-year periods. In AY 1997-98, qualified applicants may apply for a planning grant or for a grant for the purpose of developing and implementing a specific innovative future training program responsive to Medicaid policy priorities,

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including developing new educational infrastructure for a system of training involving managed care arrangements.

~~For awards to be~~ made in 1997, it ~~is estimated~~ the Innovations in Health Professions Education Grant Pool will be set at $10 million. ~~Grants may be awarded up to a total of $10 million~~. In the event the full amount of this pool is not awarded, the balance not awarded will be transferred to the primary care pool and distributed no later than June, 1998. Payments from this pool will be made monthly based on submitted expenditure reports to a hospital member of each consortium. The hospital will be responsible to distribute funds to other consortium members and for financial record keeping.

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IV. Appeals

Hospitals may review and/or appeal the components used to determine payment as well as the amount of that payment.

Beginning with rates effective October 1, 1990, hospitals will be allowed 30 days to review new data used to set rates. Hospitals will have 30 days to notify the DCH of any errors in the new data and to provide any and all supporting documentation to support their contention that the data is incomplete or inaccurate. The DCH will have 60 days after receipt of a challenge to the data to accept all or part of the correction, or to deny the hospital's request. If the hospital is not satisfied with the DCH decision, further action may be taken through the administrative appeals process. In any event, once data has been accepted by the hospital or resolved through the appeals process, no subsequent challenge to the data will be accepted by the DCH.

Appeals of price components must be received within 30 calendar days of the date of notification of a change in pricing components or of a notice of final settlement.

Appeal requests will be granted to remedy instances where incorrect data were used in the calculation of DRG prices or per diem rate or for other items deemed by the appeals panel or the administrative law judge to be within the scope of the jurisdiction as granted by the Department director.

The appeals process for pricing components includes the following steps:

1. An administrative review conducted by Medicaid Program staff that may include a meeting with representatives of the appealing hospital.

2. If the decision reached in administrative review is not acceptable to the hospital, further review by an appeal panel any be requested. The appeal panel consists of a hospital provider member, an independent member, and a representative of the Medicaid Program.

   Prior to an appeal before the appeal panel, hospitals may elect to instead present their appeal to an administrative law judge employed by the DCH. In either event, the decision of the appeal panel or law judge is forwarded to the director of the Department of Community Health who may accept, modify, or reverse the appeal panel's or the administrative law judge's finding. Both parties are notified of the decision sent to the director and have an opportunity send the director a written statement taking exception to the recommended decision.

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3. The decision by the Director shall be binding unless the hospital wishes to appeal the decision to a court of appropriate jurisdiction.

   To appeal the payment amount for individual claims, a hospital may submit additional documentation to the MSA for consideration if full or partial program payment is denied (admissions, readmissions, transfers, outliers). If a denial occurs through the prepayment editing process, a new invoice or claim adjustment may be submitted with the appropriate documentation, in accordance with established procedures. If a denial occurs through the utilization review process, appropriate additional documentation relative to the case may be submitted to the MSA, Plan Administration and Customer Services Bureau. Adjudication through provisions of the Administrative Procedures Act is available to the hospital, if resolution is not reached at the first step.

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POLICY AND METHODS FOR ESTABLISHING RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACILITIES)

3. Outpatient Hospital Services

Reimbursement to individual hospital, including off-campus satellite clinic, for outpatient services is made in accordance with Medicaid's maximum fee screens, the hospital's usual and customary charge, or Medicare's reasonable costs as required by 42 CFR 447.321, whichever is less. Outpatient hospital off-campus satellite clinics located in health manpower shortage areas as designated under Section 332 of the Public Health Services Act 42 CFR U.S.C. 254c, shall be exempt from Medicaid's maximum fee screens.

Non enrolled hospitals located outside the State of Michigan are reimbursed based on a percentage of charge basis for covered services. That percentage is 72%.

The fee for service payment system for outpatient reimbursement includes an adjustor for indigent volume. The indigent volume portion is based on the hospital's fiscal year and is recalculated each year.

Outpatient indigent volume is:

$$\textit{Indigent Volume} = \frac{\textit{Outpatient Indigent Charges}}{\textit{Total Outpatient Charges}}$$

where outpatient indigent charges equal the sum of outpatient Medicaid, Crippled Children's, and General Assistance Medical Program charges plus outpatient uncompensated care less recoveries and Hill-Burton offset.

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The indigent volume portion of the outpatient adjustor is:

$$1 + (\textit{Indigent Volume} \times .40) + .15$$

Only hospitals with at least $8,000,000 in indigent charges are eligible for the 0.15 supplement to the adjustor. Off campus satellite clinics eligible for special Medicaid reimbursement as satellite clinics in health manpower shortage areas are not eligible for the 0.15 supplement to the outpatient adjustor.

[Formula deleted.]

The outpatient adjustor is the sum of the indigent care portion of the adjustor. Hospitals not located in Michigan or not enrolled in the Medicaid Program do not receive an adjustor for indigent volume.

In addition to the regular indigent volume normally included as part of the fee screen based payments, eligible hospitals will receive a proportional share from a special indigent pool. A pool of $44,012,800 will be distributed in periodic payments between January 16, 1997 and September 30, 1997. A separate pool of up to $204,000,000 will be distributed in periodic payments between March 3, 1997 and September 30, 1997. Preliminary payments from these pools will be made to eligible hospitals based on each hospital's estimated Medicaid outpatient payments during state fiscal year 1997. Final settlement of the $204,000,000 pool will be done separately from the $44,012,800 pool, using state fiscal year (FY) 1997 paid claims data.

Eligibility for the special indigent pools are based on outpatient indigent volume data from hospital fiscal years ending between October 1, 1994 and September 30, 1995. These data have been subject to review and appeal and will not be changed.

Hospitals with outpatient indigent volume of at least 45% and outpatient indigent charges in the eligibility year (cost reports ending between October 1, 1994 and September 30, 1995) of at least $18,000,000 will be eligible for additional special outpatient indigent payments from the $44,012,800 pool.

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The cost limit is applied by each subprovider within a hospital at the time of the hospital settlement. The Medicaid outpatient payment by subprovider is limited to a maximum of the Medicaid costs for that subprovider. The cost limit test is applied to all payments including the outpatient share of direct medical education, but excluding any special indigent pool payments.

Aggregate Medicaid reimbursement to Michigan outpatient hospitals (including the special indigent pools) will not be allowed to exceed the Federally imposed upper limit for outpatient services provided to Michigan recipients. To account for varying hospital year end dates, this test will be made annually based on hospital fiscal years ending during the State fiscal year (e.g., the test for 1997 will use hospital years ending between October 1, 1996 and September 30, 1997). If the upper limit is exceeded, the size of the special indigent pool will be reduced by the amount in excess of the upper limit. If the upper limit test supports our claim that Medicaid's total payment is less than the Medicare payment would have been for comparable services under comparable circumstances, the amount up to the upper limit may be dispersed to the qualifying hospitals.

Between January 2, 1997 and September 30, 1997, qualifying children's hospitals will share in an outpatient adjustor pool of $695,000. This payment will be in addition to the regular indigent volume normally included as part of the fee screen based payments.

Eligibility for the pool is restricted to freestanding children's hospitals as defined for the purpose of the Medicaid Indigent Volume Report (Medical Assistance Program, Hospital Manual, Chapter VIII, page 19, item #3). Indigent volume charges and children's hospital status will be determined from the Medicaid Indigent Volume Report for hospital fiscal years (FY) ending between October 1, 1994 and September 30, 1995. To be eligible a children's hospital must have incurred outpatient indigent volume charges (for hospital fiscal years ending between October 1, 1994 and September 30, 1995) in excess of $35,000,000. These data have been subject to review and appeal and will not be changed. Each eligible hospital will share in the pool proportionately using the ratio of the hospital's FY 1997 Title XIX estimated outpatient charges to the sum of FY 1997 Title XIX estimated outpatient charges for qualifying hospitals.

The $695,000 will be paid on or after January 2, 1997. This payment will be made based on the best data available.